EXHIBIT Y

Estate of Stephen Johnson

VCF Documentation

September 11th
Victim Compensation Fund

February 11, 2020

GRESY JOHNSON
C/O WENDELL TONG
SULLIVAN PAPAIN BLOCK MCGRATH & CANNAVO, PC
120 BROADWAY 18TH FLOOR
NEW YORK NY 10271

Dear GRESY JOHNSON:

The September 11th Victim Compensation Fund ("VCF") previously sent you a letter notifying you of the eligibility decision on the claim you submitted on behalf of STEPHEN JOHNSON. Your claim number is VCF0094498. The letter explained that the VCF had reviewed your claim and determined you were not eligible for compensation because you did not timely register your claim by the applicable deadline.

You then appealed the eligibility decision on your claim and are waiting for your hearing to be scheduled and/or held.

The VCF has now determined that your claim is timely registered and you meet the eligibility criteria established in the statute and regulations. The hearing on your claim has therefore been cancelled. On July 29, 2019, the President signed into law the Never Forget the Heroes: James Zadroga, Ray Pfeifer, and Luis Alvarez Permanent Authorization of the September 11th Victim Compensation Fund Act ("VCF Permanent Authorization Act"), which extended the VCF until October 1, 2090. As a result, the Special Master has determined that all claims are considered timely if registered by July 29, 2021, which is two years from the date of the Permanent Authorization Act. Because you submitted your registration prior to July 29, 2021, your claim is now considered timely.

Based on the information you submitted with your claim and information the VCF has received from the World Trade Center ("WTC") Health Program, you have been found eligible for the following injuries:

- CHRONIC LYMPHOID LEUKEMIA/SMALL LYMPHOCYTIC LYMPHOMA

Please note that there are several reasons why an injury that you think should be eligible is not listed above. For non-traumatic injuries, the name of the injury is based on the information provided by the WTC Health Program and there may be different names for the same injury. Additionally, your injury may not be listed if it was only recently certified for treatment by the WTC Health Program.

If in the future the WTC Health Program should notify you that a condition previously found eligible is no longer certified, you must inform the VCF as this may affect your eligibility status and/or the amount of your award.

September 11th
Victim Compensation Fund

What Happens Next

If the decedent has been certified for treatment by the WTC Health Program for a condition not listed above, you should amend your claim. Please see the VCF website for details on how to amend your claim. The VCF will review the new information and determine if it provides the basis for a revised decision.

If the decedent did not have injuries other than those listed above, you should submit the compensation section of your claim form and the required supporting materials if you have not already done so. **If you have already submitted this information, you do not need to take any action at this time unless you receive a request from the VCF for missing information**. The VCF will calculate the amount of any compensation based on the conditions listed above after all compensation-related documents are submitted.

If you have questions about the information in this letter or the claims process in general, please call our toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

Sincerely,

Rupa Bhattacharyya
Special Master
September 11th Victim Compensation Fund

cc: GRESY JOHNSON

September 11th
Victim Compensation Fund

September 25, 2020

GRESY JOHNSON
C/O WENDELL TONG
SULLIVAN PAPAIN BLOCK MCGRATH & CANNAVO, PC
120 BROADWAY 18TH FLOOR
NEW YORK NY 10271

Re: CLAIM NUMBER: VCF0094498

Dear GRESY JOHNSON:

The September 11th Victim Compensation Fund ("VCF") has reviewed your claim for compensation. Your claim form was determined to be substantially complete on September 22, 2020. This means your claim was deemed "filed" for purposes of section 405(b)(3) of the Statute on that date.

After reviewing the responses in your claim form, the documents you submitted in support of your claim, and information from third-party entities, the VCF has calculated the amount of your award as [redacted]. This determination is in accordance with the requirements of the Never Forget the Heroes: James Zadroga, Ray Pfeifer, and Luis Alvarez Permanent Authorization of the September 11th Victim Compensation Fund Act ("VCF Permanent Authorization Act"). The enclosed "Award Detail" includes a detailed explanation of the calculation and a list of the eligible conditions that were considered when calculating your award.

The award includes burial expenses as well as lost earnings and replacement services beginning on the date of Mr. Johnson's death. We did not award lost earnings for the period between when he was diagnosed with his eligible condition and when he died as there is no disability determination to serve as a basis for an award. We did not award replacement services for that period either, as such awards are generally reserved for individuals who did not work outside the home. We considered your argument for not offsetting the life insurance proceeds, but the VCF statute requires us to offset life insurance and there do not appear to be any extraordinary circumstances that would warrant not doing so.

No non-routine legal service expenses are approved for reimbursement for this claim.

As the Personal Representative, you are required to distribute any payment received from the VCF on behalf of the victim to the eligible survivors or other recipients in accordance with the applicable state law or any applicable ruling made by a court of competent jurisdiction or as provided by the Special Master.

What Happens Next

The VCF will deem this award to be final and will begin processing the full payment on your claim unless you complete and return the enclosed Compensation Appeal Request Form

within **30 days from the date of this letter** as explained below. If you do not appeal, the Special Master will authorize the payment on your claim within 20 days of the end of the 30-day appeal period. Once the Special Master has authorized the payment, it may take up to three weeks for the United States Treasury to disburse the money into the bank account designated on the VCF ACH Payment Information Form or other payment authorization document you submitted to the VCF.

- **Appealing the Award**: You may request a hearing before the Special Master or her designee if you believe the amount of your award was erroneously calculated, or if you believe you can demonstrate extraordinary circumstances indicating that the calculation does not adequately address your loss. **If you choose to appeal, your payment will not be processed until your hearing has been held and a decision has been rendered on your appeal**.

  To appeal the award, you must complete two steps by the required deadlines:

  1. Complete and return the enclosed **Compensation Appeal Request Form** within **30 days from the date of this letter**. Follow the instructions on the form and upload it to your claim or mail it to the VCF by the required deadline. If you do not submit your completed Compensation Appeal Request Form within 30 days of the date of this letter*, you will have waived your right to an appeal* and the VCF will begin processing any payment due on your claim.
  2. Complete and submit your **Compensation Appeal Package** (Pre-Hearing Questionnaire, Compensation Explanation of Appeal, and all applicable supporting documents) no later than **60 days from the date of this letter**. It is important that you carefully review the information enclosed with this letter and follow the instructions if you intend to appeal your award. Additional instructions on the appeals process can be found on the VCF website under “Frequently Asked Questions” and in the Policies and Procedures available under “Forms and Resources.”

  Once your complete Compensation Appeal Package is submitted, the VCF will review the information to confirm you have a valid appeal, and will notify you of the next steps specific to your appeal and the scheduling of your hearing.

- **Notifying the VCF of new Collateral Source Payments**: You must inform the VCF of any new collateral source payments you receive, or become entitled to receive, such as a change to your disability or survivor benefits, as this may change the amount of your award. If you notify the VCF within 90 days of learning of the new collateral source payment, your award will not be adjusted to reflect the new entitlement or payment. If you notify the VCF more than 90 days after learning of the new or revised entitlement or payment, the VCF may adjust your award to reflect the new payment as an offset, which may result in a lower award. If you need to notify the VCF of a new collateral source payment, please complete the “Collateral Offset Update Form” found under “Forms and Resources” on the www.vcf.gov website.

September 11th
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Your award was calculated using our published regulations, and I believe it is fair and reasonable under the requirements of the VCF Permanent Authorization Act. As always, I emphasize that no amount of money can alleviate the losses suffered on September 11, 2001.

If you have any questions, please call our toll-free Helpline at 1-855-885-1555. Please have your claim number ready when you call: **VCF0094498**. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

Sincerely,

Rupa Bhattacharyya
Special Master
September 11th Victim Compensation Fund

cc: GRESY JOHNSON

September 11th
Victim Compensation Fund

Award Detail

Claim Number: VCF0094498
Decedent Name: STEPHEN JOHNSON

PERSONAL INJURY CLAIM (Losses up to Date of Death)	
Lost Earnings and Benefits	
Loss of Earnings including Benefits and Pension	$0.00
Mitigating or Residual Earnings	$0.00
Total Lost Earnings and Benefits	$0.00
Offsets Applicable to Lost Earnings and Benefits	
Disability Pension	$0.00
Social Security Disability Benefits	$0.00
Workers Compensation Disability Benefits	$0.00
Disability Insurance	$0.00
Other Offsets related to Earnings	$0.00
Total Offsets Applicable to Lost Earnings	$0.00
Total Lost Earnings and Benefits Awarded	$0.00
Other Economic Losses	
Medical Expense Loss	$0.00
Replacement Services	$0.00
Total Other Economic Losses	$0.00
Total Economic Loss	$0.00
Total Non-Economic Loss	[redacted]
Subtotal Award for Personal Injury Claim	[redacted]

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DECEASED CLAIM (Losses from Date of Death)	
Loss of Earnings including Benefits and Pension	[redacted]
Offsets Applicable to Lost Earnings and Benefits	
Survivor Pension	$0.00
SSA Survivor Benefits	[redacted]
Worker's Compensation Death Benefits	$0.00
Other Offsets related to Earnings	$0.00
Total Offsets Applicable to Loss of Earnings and Benefits	[redacted]
Total Lost Earnings and Benefits Awarded	[redacted]
Other Economic Losses	
Replacement Services	[redacted]
Burial Costs	[redacted]
Total Other Economic Losses	[redacted]
Total Economic Loss	[redacted]
Non-Economic Loss	
Non-Economic Loss - Decedent	[redacted]
Non-Economic Loss - Spouse/Dependent(s)	[redacted]
Total Non-Economic Loss	[redacted]
Additional Offsets	
Social Security Death Benefits	[redacted]
Life Insurance	[redacted]
Other Offsets	$0.00
Total Additional Offsets	[redacted]
Subtotal Award for Deceased Claim	[redacted]

September 11th
Victim Compensation Fund

Subtotal of Personal Injury and Deceased Claims	[redacted]
PSOB Offset	$0.00
Prior Lawsuit Settlement Offset	$0.00
TOTAL AWARD	[redacted]
Factors Underlying Economic Loss Calculation	
Annual Earnings Basis (without benefits)	[redacted]
Percentage of Disability attributed to Eligible Conditions - applicable to Personal Injury losses	
Start Date of Loss of Earnings Due to Disability - applicable to Personal Injury losses	

Eligible Conditions Considered in Award
Chronic Lymphoid Leukemia/small Lymphocytic Lymphoma

THE CITY OF NEW YORK

VITAL RECORDS CERTIFICATE

DEATH TRANSCRIPT

DATE FILED THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Certificate No. 156-10-046933

NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE
NOVEMBER 30, 2010 09:02 AM

1. DECEDENT'S LEGAL NAME: STEPHEN JOHNSON (First, Middle, Last)

MEDICAL CERTIFICATE OF DEATH (To be filled in by the Physician)

Place Of Death: 2a. New York City; 2b. Borough: Manhattan

2c. Type of Place: 1 ☒ Hospital Inpatient; 2 ☐ Emergency Dept./Outpatient; 3 ☐ Dead on Arrival; 4 ☐ Nursing Home/Long Term Care Facility; 5 ☐ Hospice Facility; 6 ☐ Decedent's Residence; 7 ☐ Other Specify

2d. Any Hospice care in last 30 days: 1 ☐ Yes; 2 ☒ No; 3 ☐ Unknown

2e. Name of hospital or other facility (if not facility, street address): Memorial Sloan-Kettering Cancer Center

Date and Time of Death	3a. (Month)	(Day)	(Year-yyyy)	3b. Time		4. Sex	5. Date last attended by a Physician mm	dd	yyyy
	November	28	2010	09:58	☒ PM	Male	11	28	2010

6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. **See instructions on reverse of certificate.**

Name of Physician: Fawad Chaudry (Type or Print)

Signature: Fawad Chaudry ☒ M.D.

Signature Electronically Authenticated

Address: 1275 York Avenue, New York, New York 10065

License No. 251224 Date: NOV-28-2010

PERSONAL PARTICULARS (To be filled in by Funeral Director or, in case of City Burial, by Physician)

7a. Usual Residence State	7b. County	7c. City or Town	7d. Street and Number	Apt. No.	ZIP Code	7e. Inside City Limits?
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	1 ☒ Yes 2 ☐ No

8. Date of Birth (Month)	(Day)	(Year-yyyy)	9. Age at last birthday (years)	Under 1 Year: Months	Days	Under 1 Day: Hours	Minutes	10. Social Security No.
[redacted]	[redacted]	[redacted]	47	2	3	4	5	[redacted]

11a. Usual Occupation (Type of work done during most of working life. Do not use "retired")	11b. Kind of business or industry	12. Aliases or AKAs
Self Employed Furniture Store Owner	Blue Bench llc, NY	Stephen Paul Johnson

13. Birthplace (City & State or Foreign Country): Teaneck, New Jersey

14. Education (Check the box that best describes the highest degree or level of school completed at the time of death)
1 ☐ 8th grade or less; none
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (e.g., AA, AS)
6 ☒ Bachelor's degree (e.g., BA, AB, BS)
7 ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
8 ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No

16. Marital/Partnership Status at time of death
1 ☒ Married 2 ☐ Domestic Partnership 3 ☐ Divorced
4 ☐ Married, but separated 5 ☐ Never Married 6 ☐ Widowed
7 ☐ Other, Specify 8 ☐ Unknown

17. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage)(First, Middle, Last): Gresy Alvarez

18. Father's Name (First, Middle, Last): John A. Johnson

19. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last): Mary Correll

20a. Informant's Name	20b. Relationship to Decedent	20c. Address (Street and Number Apt. No. City & State ZIP Code)
Gresy Johnson	Spouse	[redacted]

21a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Entombment 4 ☐ City Cemetery
5 ☐ Other Specify

21b. Place of Disposition (Name of cemetery, crematory, other place): Hillside Cemetery

21c. Location of Disposition (City & State or Foreign Country): Metuchen, New Jersey

21d. Date of Disposition: mm 12 dd 02 yyyy 2010

22a. Funeral Establishment: Bergen Funeral Service

22b. Address (Street and Number City & State ZIP Code): 2009 Mermaid Avenue, Brooklyn, New York 11224

VR 15 (Rev. 01/09)

This is to certify that the foregoing is a true copy of a record on file in the Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

Do not accept this transcript unless it bears the security features listed on the back. Reproduction or alteration of this transcript is prohibited by §3.19(b) of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

DATE ISSUED November 30, 2010 Order No. 20101106711

Steven P. Schwartz, Ph.D., City Registrar

W 0 0 6 4 6 1 4 4

The City of New York

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

September 11th Victim Compensation Fund Claim

Claimant Gresy Johnson, as Personal Representative of the Estate of Stephen Johnson (deceased)

VCF0094498

Cause of Death Summary

Medical records establish cause of death was Leukemia

Decedent was diagnosed with Leukemia in March 2008 (see page 1, attached).

He died two years later, at Memorial Sloan Kettering Cancer Center ("MSK"), on November 28, 2010, after two years of treatment, which included chemotherapy, blood transfusions, radiation, and various scans.

The medical records confirm that claimant died of Leukemia.

Claimant was admitted at MSK on November 8, 2010 where he remained hospitalized until the day he died, on November 28, 2010.

The Admission note of November 8, 2010, confirms the diagnosis of "**Non-Hodgkin Lymphoma**" and that claimant was "**awaiting allogeneic hematopoietic stem cell transplantation**..." (see page 2).

On November 12, 2010, claimant was "**continuing transplant conditioning**." (see page 3).

On November 24, 2010, the doctor confirmed that claimant has "**progressive high risk disease**" (see page 4).

On November 26, 2010, two days before decedent's death, the doctor reported "**partial relapse**." (see page 5).

The Discharge Summary dated November 28, 2010, the day decedent died, confirms:

> "**ADMISSION DIAGNOSIS: Chronic lymphocytic leukemia...containing Hodgkin's lymphoma**..."

> **"REASON FOR ADMISSION**: Admitted for unmodified peripheral **blood stem cell transplant** from matched unrelated donor."
>
> (see pages 6-8).

Attached with this summary are medical excerpts for the VCF's convenience and review. The entire medical chart from MSK has been uploaded to the claim.

Respectfully, the cause of death has been established.

Conclusion

The medical records from MSK confirm that decedent was hospitalized from November 8, 2010 to November 28, 2010 due to Leukemia, and that he died in the hospital due to Leukemia.

Respectfully, the cause of death has been established.

Dated: January 23, 2019

Respectfully submitted,

Ina Pecani, Esq.
SULLIVAN PAPAIN BLOCK
MCGRATH & CANNAVO P.C.
120 Broadway, 18th Floor
New York, NY 10271
Main (212) 732-9000
Direct (212) 266-4142
ipecani@triallaw1.com

RTE: AFSILH SEQ: UFKL

DIANON *Systems*
A LabCorp Company

HEMATOPATHOLOGY REPORT

Surgical Pathology number: SJ8000248

29302065 ADDENDED REPORT
Phone: 908-754-0400 Fax: 03/05/08
HEMATOLOGY ONCOLOGY ASSOC

1314 PARK AVENUE
PLAINFIELD, NJ 07060-3253 NJB15

Accession No.	Chart No.	Sex	D.O.B.	Page
056-G42-0005-0	142584228	M	[redacted]44 Yrs	1 of 3

Patient Name: JOHNSON, STEPHEN P (142584228)	Collected: 02/25/08
Requesting Physician: LEFF	Received: 02/27/08
Referring Physician:	Reported: 03/05/08
Indications For Study:	

FINAL DIAGNOSIS

Bone Marrow

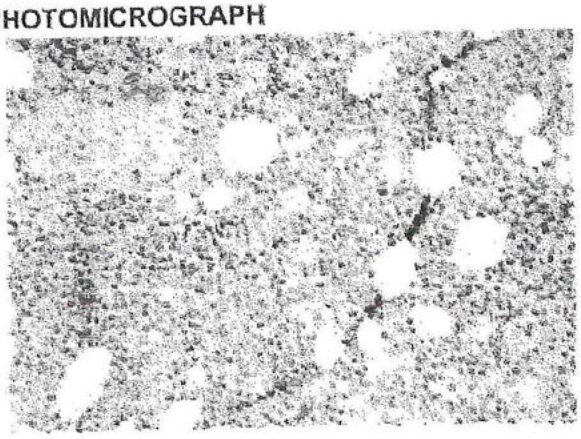
1. Chronic lymphocytic leukemia/Small lymphocytic lymphoma, 70% bone marrow involvement.

2. Reduced bone marrow trilineage hematopoiesis.

Comment
Flow cytometry showed a monoclonal kappa positive B cell population coexpressing CD5, CD23, consistent with CLL/SLL. Clinical correlation is recommended.

This case was reviewed at the hematopathology consensus conference.

PHOTOMICROGRAPH



Addendum
This case is addended to include peripheral blood morphology. The diagnosis is unchanged.

Clinical Information
44 year old male with chronic lymphocytic leukemia.

Gross Description
BONE MARROW CORE:
Received in formalin are 3 homogeneous bone marrow cores measuring 0.3 cm in length x 0.2 cm in diameter to 0.2 cm in length and 0.2 cm in diameter. Specimen is submitted in toto in 1 cassette. Associated clot measures 0.9 x 0.4 x 0.2 cm and is submitted in the same cassette. Specimen may further fragment with processing. The specimen has been decalcified to reduce fragmentation during sectioning.
BONE MARROW CLOT:
Received in formalin is clot measuring 1.9 x 1.7 x 0.3 cm in aggregate. Specimen is submitted in toto in 1 cassette.

Peripheral Blood
CBC values: WBC 40.1, Lymph 32.0, RBC 4.36, Hgb 13.5, Hct 38.3, MCV 88, MCHC 35.2, RDW 14.2, Platelets 178

Peripheral blood smear is subsequently received. Red blood cells show mild anisocytosis. There is a moderate lymphocytosis.

1912 Alexander Drive
RTP NC 27709-0000
1-800-735-4087

1

MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES

Admission Note - BMT

JOHNSON, STEPHEN MRN: 35197181 DOB: [redacted] 47y M
DATE: 11/08/2010 - 11/28/2010 ACCT: 8451859288 PROVIDER: Jenq, Robert (MD) 013805

Last Updated: 11/08/2010 06:58 PM
Service Date: 11/08/2010 06:53 PM

Admission Data:

- Primary attending: Dr. Goldberg.

Chief Complaint:

- **Diagnoses:** Non-Hodgkin Lymphoma
- **Chief Complaint:** Mr. Johnson is a 47 yo gentleman with no significant past medical history who is awaiting allogeneic hematopoietic stem cell transplantation for transformed chronic lymphocytic leukemia. His transformed component is currently in a partial remission with remaining bulky hypermetabolic LAN.[1]

History of Present Illness:

Mr. Johnson was first diagnosed with chronic lymphocytic leukemia in 04/2008. The development of a cough prompted a CBC that revealed an elevated WBC of 29.6 with 81% lymphocytes. His hemoglobin was 14.4 and his platelets were 120,000. A bone marrow evaluation performed 2/25/08 revealed a bone marrow that was 90% cellular with an increase in the number of small/mature lymphocytes. Flow cytometry revealed a kappa restricted CD5 positive, CD19 positive, CD23 positive clonal population. ZAP 70 was positive. In his peripheral blood, unmutated immunoglobulin heavy chains were noted. FISH was positive for an 11q deletion and a 13q deletion. A CT of his chest, abdomen and pelvis performed 3/3/08 revealed bilateral axillary, mediastinal and hilar lymphadenopathy. The largest lymph node above the diaphragm was a left axillary lymph node measuring 3 cm. Multiple abdominal and retroperitoneal lymph nodes were noted. Pelvic lymphadenopathy was noted with extension to bilateral inguinal lymph nodes. A right pelvic sidewall mass measured 9.5 x 3.5 cm, a left pelvic sidewall mass measured 6.3 x 3.8cm.

Mr Johnson presented to Dr. Nicole Lamanna at MSKCC on 4/3/10. He was observed until 09/2009 when he presented with an abdominal mass and fevers and PET scan highly suspicious for transformed disease with nodal and extranodal involvement with SUVs in excess of 30. For example, a right humerus lesion had an SUV of 34, a sternal lesion an SUV of 35, a left hilar lesion had an SUV of 28, a right lower lobe lesion had an SUV of 11, a liver mass an SUV of 25, a pelvic mass measuring 14 x 9 cm had an SUV of 23. Because Mr. Johnson was too ill to receive a biopsy at that time secondary to hypotension and atrial fibrillation, he was treated empirically for transformed disease with R-CHOP therapy. He obtained a good clinical response from this therapy. Unfortunately, a post treatment PET was consistent only with a partial response. A biopsy at that time on 04/12/2010 was consistent with Richter transformation with Hodgkin's lymphoma features. Cytogenic did not reveal clonal evolution. Bone marrow evaluation performed on 05/25/2010 was positive for involvement of CLL.

For his high risk CLL, Dr. Lamanna treated Mr. Johnson with PCRM on protocol #05-077. He progressed on one cycle of therapy. He subsequently received therapy with RICE starting on 08/13/2010. He has received three cycles with his last cycle 10/05/2010. He has tolerated therapy quite well and notes only mild fatigue and nausea. His post treatment PET scan is consistent with a very good partial response. Significant improvement and near resolution of abnormal FDG uptake and lymph nodes of neck was noted with a complete resolution in the chest seen. Resolution of his right pleural effusion was noted. Resolution of hypermetabolic liver disease was noted. Essentially resolution of hypermetabolic lymphadenopathy in the upper abdomen and some mild enlarged lymph nodes noted on CT. Significant improvement but clearly persistent hypermetabolic lymphadenopathy was noted in the retroperitoneum and in particular in the left hemipelvis. There was also persistent disease infiltration of the left

(2)

MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES

Progress Note - BMT

JOHNSON, STEPHEN	**MRN: 35197181**	DOB: [redacted]	47y M
DATE: 11/08/2010 - 11/28/2010	ACCT: 8451859288	PROVIDER: Jenq, Robert (MD) 013805	

Last Updated: 11/12/2010 10:48 AM

Service Date: 11/12/2010 10:44 AM

Interim History:

Continuing transplant conditioning. No complaints except fatigue.

Physical Examination:

- Vital signs: beside chart reviewed and stable notable for.
- General: alert; oriented; appropriate; no distress .
- HEENT: OP clear .
- Catheter site: clean without erythema.
- Lungs: clear bilaterally.
- Heart: regular; no murmurs .
- Abdomen: nondistended; nl BS; soft; nontender; no HSM .
- Extremities: no edema bilaterally.
- Neurologic: nonfocal.
- Skin: no rashes.

Laboratory Results:

- In view of the patient's diagnosis and condition the lab data/studies have been ordered under my supervision. I have reviewed and noted the lab data as ordered .

Impression/Plan:

- Primary cancer diagnosis: Transformed CLL with Hodgkin lymphoma features. He is in partial remission with regards to transformed component.
- Cytogenetic/molecular markers: 11q-, 13q-.
- Additional cancer diagnoses: none.
- Comorbidities: mildly decreased DLCO when corrected for Hgb
  S/p XRT boost to residual bulky lymphadenopathy in L pelvis/retroperitoneum.
- Patient: ABO: B pos CMV: NEG EBV: POS Toxo: NEG.
- Serologies: VZV+, otherwise negative.
- Donor: ABO: B pos CMV: NEG EBV: Toxo:.
- Preparative Regimen: Protocol: OFF p'col Conditioning: TBI, thio hi-cy. No ATG KGF pre/post.
- Graft: Manipulation: unmodified Graft Type: PBSC. Donor: matched unrelated Sex: male ID: 0226-8929-3.
- Fungal hx/risk: high, h/o radiographic infection.
- MRSA: NEG surveillance.
- VRE: NEG surveillance.
- GvHD ppx: TAC/MTX.
- HSCT date: 11/19/10.
- Day pre/post: -7.
- Mucositis: Grade: 0 - no changes ;.
- Engraftment: undergoing preparative regimen; anemic .
- Transfusion support: per service guidelines.

3

CONTAINS PROTECTED HEALTHCARE INFORMATION - HANDLE ACCORDING TO MSKCC POLICY

Memorial Hospital for Cancer and Allied Diseases

35197181 8451859288 [redacted] M

Progress Notes

JOHNSON, STEPHEN

Goldberg, Jenna Castro-Malaspina, Hugo

Date:

ALL ENTRIES MUST BE SIGNED, DATED, TIMED, AND LEGIBLE. PRINT LAST NAME AND BEEPER OR EXTENSION.

Use DAILY - not ~~QD~~ • Use MORPHINE - not ~~MS, MS04~~ • Use UNITS - not ~~U~~

DATE: 11/24/10 TIME: 0400 CCM Resident Progress Note

HPI: 47 yo M with CLL diagnosed in 2/2008 initially on expectant monitoring who developed progressive high risk disease. CT Chest/abd/pelvis done then showed multiple enlarged b/l axillary, mediastinal and hilar LN, mediastinal nodes extending into superior, middle and anterior mediastinum. LN in prevascular, pre and para tracheal regions, pre and subcarinal regions, some small paraesophageal nodes. Under observation until 9/09, when presented with new abdominal mass, fevers and weight loss; admitted for symptomatic progressive disease. PET 9/9/09 showed marked increase in SUV uptake in R humerus, sternum, L hilum, RLL, liver, left pelvic mass. Developed afib with difficult to control HR, fevers and hypotension. In setting of high SUVs and high LDH, treated with R-CHOP chemotherapy for transformed disease with split dose steroids 9/22 – 9/25/09. Received six cycles of chemotherapy up until 1/12/10. Post treatment CT/PET on 3/18/10 showed persistent uptake in liver and nodes in external iliac base, with some improvement in lymph node regions (decreased SUV in ant mediastinal mass, prevascular LN, liver mass, para aortic, bone lesions; stable pelvic LN). Laparoscopic Bx on 4/12/10 showed Richter syndrome with Hodgkin's lymphoma, repeat PET showed diffuse increase in lymphadenopathy, BM 5/25/10 positive for CLL. Enrolled in Protocol #05-077 with pentostatin, cyclophosphamide, rituximab and mitoxantrone. Received first cycle PCM June, second cycle with rituximab 7/8/10. Admitted with cough and fever, imaging revealed increased disease. PET 9/9/10 showed increase in lymphadenopathy in chest, abdomen, pelvis, with new liver lesions and new pleural mass, and increase in abdominal wall mets. Renal scan 8/10/10 for acute renal failure showed thickening of bladder wall. Chemotherapy switched to RICE, three cycles received, last 8/5/10. Post treatment PET with good partial response, near resolution of neck LN and complete resolution of chest, R pl effusion, liver disease, upper abdomen. Persistent retroperitoneal and L hemi pelvic disease, and L ant abdominal wall. Admitted for total body irradiation and allogeneic stem cell transplant. Post transplant course c/b c. diff colitis with large volume diarrhea, afib with RVR, and doubling of Cr. Decreased CO2, with pain at port. Concern for possible urosepsis, although tacrolimus level high. Given NS 500 cc, 2 units platelets, 1 unit PRBCs. HR 168-140s, BP 130/40, satting 98% on RA. Afebrile, started on Vanco, given one dose Zosyn. Given Lasix, without any urine output. Positive 800 cc net balance. Lopressor 10 mg without response, diltiazem with decrease to 130s. Brought to ICU for possible sepsis, and worsening renal and hepatic function.

Allergies: NKDA
Lines: L radial aline, L IJ CVC
ON Events: 0.1T off yesterday → Trach ON → 140's → 170's - 0.1T re-loaded

NEURO:
MENTAL STATUS: AAO.
Sedation Meds: Pain meds: Other:
□ Fentanyl gtt _____ mcg/hr □ PCA
□ Midazolam gtt _____ mg/hr □ Other

PULMONARY: ~~OF 30% 2011 → 4LNC. Resp 20's~~
Lung exam: O2Sat: Fio2: Sats- 95-99
RR: LA: 0.8
ABG: 7.43/23/217/16

ASMNTS

99-99190 P32 CIMC Approval Date: 6/96

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CONTAINS PROTECTED HEALTHCARE INFORMATION - HANDLE ACCORDING TO MSKCC POLICY

Memorial Hospital for Cancer and Allied Diseases

Progress Notes

ACCT
NAME: JOHNSON, Stephen
MRN: 35197181
BED: 19

Date: 11/26/10 05:00 PM

ALL ENTRIES MUST BE SIGNED, DATED, TIMED, AND LEGIBLE. PRINT LAST NAME AND BEEPER OR EXTENSION.

Use DAILY - ~~not QD~~ Use MORPHINE - ~~not MS, MS04~~ Use UNITS - ~~not U~~

CCM ATTENDING PROGRESS NOTES

The patient has been examined, the case assessed, labs and images reviewed, and the care plan formulated with the multidisciplinary critical care team. Please see the CCM fellow's and resident's notes for additional details of clinical data.

Mr. Johnson is a 47-year-old man with chronic lymphocytic leukemia with Richter transformation containing Hodgkin's lymphoma features and history of MCL repair 30 years ago. In February 2008 he developed a cough and CBC revealed leukocytosis with lymphocyte predominance. Bone marrow evaluation revealed increased number of small/lymphocyte predominance and CT imaging in March 2008 revealed axillary, mediastinal, hilar, abdominal, pelvic and retroperitoneal lymphadenopathy. He presented to MSK in April 2008 and was followed clinically since he did not meet specific criteria requiring therapy at that time. In September 2009 he was noted to have developed an abdominal mass and a PET scan revealed innumerable foci of hypermetabolic activity involving the bone, lymph nodes, lung and liver. He was admitted to the ward for further management but developed fever, hypotension and atrial fibrillation. Biopsy was unable to be obtained because of his clinical status and due to clinical concern for presumed transformation he was started on R-CHOP, which was completed in January 2010. Followup radiographic imaging in March 2010 was consistent with partial response with decrease in metabolic activity in certain lymph nodes and bone however lymph node response was variable. He underwent a biopsy of the left external iliac lymph node on 4/12/10 that was consistent with Richter transformation with Hodgkin's lymphoma features. Repeat imaging in May 2010 revealed diffuse increase in size of the adenopathy as well as an increase in uptake. Bone marrow evaluation on 05/25/10 was positive for involvement with CLL. He was started treatment with PRCM under protocol #05-077 from June to July 2010. A CT at the end of July revealed increasing size of hepatic mass and he was admitted to MSK in early August with increased weakness, fever and cough. PET imaging in August revealed increase in number and intensity of lymphadenopathy. Therefore, he began treatment with RICE. He was then evaluated for allogeneic HSCT. Chemotherapy was completed on 10/05/10 and followup PET imaging was consistent with a good partial response with persistent hypermetabolic activity in the retroperitoneum, left hemipelvis and left anterior abdominal wall. On 11/19 he received a PBSCT from a matched unrelated donor. The hospital course was complicated by *C. difficile* colitis diagnosed on 11/17, rising creatinine and atrial fibrillation. On the afternoon of 11/22, he developed rapid atrial fibrillation and a Critical Care consult was called for ICU admission. In the ICU a left radial arterial line was placed and he was started on diltiazem infusion for rate control. Antimicrobial coverage was also broadened for possible sepsis. RUQ sono on 11/23 was negative for VOD. On 11/24 he developed worsening tachycardia and hypotension that required 3 vasopressors at maximal doses. A left subclavian CVC was placed emergently and IR removed the tunneled CVC at the bedside. Throughout the course of the day vasopressors were weaned and HR slowly improved. Overnight he continued to have episodes of sustained tachycardia to the 170's and amiodarone was started.

On exam, he is comfortable without focal complaints. He is breathing comfortably at 13/min on 30% OptiFlow with oxygen saturation of 100%. ABG shows pH of 7.45, $PaCO_2$ of 25, PaO_2 of 235. CXR shows decreased bibasilar opacities and effusions with the left subclavian CVC in proper position. BP is 100/55 and HR of 103/min in atrial fibrillation on low dose phenylephrine infusion and amiodarone infusion. Heart sounds are irregular without murmur or rub. Overall fluid balance is +2L with urine output of 70-100 cc/hr. BUN/creatinine are elevated but stable at 41/3.1. Sodium is 135, potassium is 3.5, total CO_2 is 18, magnesium is 2.0 and phos of 4.1. He was afebrile with WBC 0.0 and he is receiving vancomycin by level, piperacillin/tazobactam, metronidazole, micafungin and acyclovir prophylaxis. Blood cultures from the CVC grew coagulase negative Staph and the CVC was removed on 11/24. He is NPO, and TPN was held due to bacteremia, with glucose at 145. LFT's show TB of 5.6, alk phos of 35, and AST of 15. Abdomen is soft and nontender. His hemoglobin is 8.1 and platelets are 19, both supported by intermittent transfusions. Coagulation profile shows PT 24.6, INR 2.20 and aPTT 48.0. He is receiving pantoprazole for GI prophylaxis and SCDs for DVT prophylaxis. He is receiving mycophenolate for GVHD prophylaxis and BMT is following tacrolimus levels.

In summary, Mr. Johnson is a 47-year-old man with CLL with partial relapse now s/p PBSCT on 11/19. The transplant course has been complicated by *C. diff* colitis, elevated creatinine and rapid atrial fibrillation. He required ICU admission on 11/22 due to rapid atrial fibrillation. Active issues include respiratory insufficiency, atrial fibrillation, nonoliguric renal failure, volume overload, sepsis, pancytopenia, hyperbilirubinemia and s/p HSCT. Our plan for the day is to continue oxygen supplementation, taper phenylephrine infusion, continue amiodarone, Cardiology follow up, diuresis with furosemide & aim for even/negative fluid balance, continue current antimicrobials, follow repeat blood cultures, hold TPN, supportive transfusions and continue ICU and BMT prophylactic regimens.

Aggregate time spent in care of this critically ill patient, reviewing the medical record, test results and imaging studies, discussing the case with house staff and attendings, coordinating care, and documenting CCM services in the record, exclusive of time spent performing medical procedures, is 60 minutes.

CCM Attending Sanjay Chawla
Sanjay Chawla, MD

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Memorial Hospital for Cancer and Allied Diseases
Discharge Summary

Patient Name:	JOHNSON,STEPHEN	Medical Record No:	35197181
Account No:	8451859288	Admission Date:	11/08/2010
Service:	INTENSIVE CARE UNIT	Discharge Date:	11/28/2010
Attending:	HUGO CASTRO-MALASPINA	Date of Birth:	[redacted]
Att MD No:	000828	Age:	47
Primary:	JENNA GOLDBERG,MD	Sex:	MALE
Prim MD No:	015552	Previous Admission:	YES

ADMISSION DIAGNOSIS: Chronic lymphocytic leukemia with Richter transformation containing Hodgkin's lymphoma features, in partial remission

REASON FOR ADMISSION: Admitted for unmodified peripheral blood stem cell transplant from matched unrelated donor

BRIEF HISTORY: The patient was 47-year-old male with chronic lymphocytic leukemia diagnosed in 02/2008 was initially on expectant monitoring who developed progressive high risk disease. He underwent CT chest, abdomen and pelvis which showed multiple enlarged bilateral axillary, mediastinal and hilar lymph nodes with mediastinal nodes extending into superior, middle and anterior mediastinum. He was under observation till 09/2009, when he presented with new abdominal mass, fever and weight loss with symptomatic progressive disease. He underwent PET scan on 09/09/2009 which showed marked increase in SUV uptake in right humerus, sternum, left hilum, right lower lobe, liver and left pelvic mass. He then developed atrial fibrillation with increased heart rate, fever and hypotension. He was treated with R-CHOP chemotherapy for transformed disease with split dose steroids from 09/22/2009-09/25/2009 and received 6 cycles of chemotherapy till 1/12/2010. CT/PET on 3/18/2010 showed persistent uptake in liver and nodes in external iliac base and laparoscopic biopsy on 4/12/2010 revealed Richter syndrome with Hodgkin's lymphoma and bone marrow biopsy on 5/25/2010 was positive for Chronic lymphocytic leukemia. He was then enrolled for protocol #05-077 with Pentostatin, Cyclophosphamide, Rituximab and Mitoxantrone. He underwent PET on 09/09/2010 which showed increased lymphadenopathy in chest, abdomen and pelvis and renal scan on 08/10/2010 showed acute renal failure and chemotherapy was switched to RICE with last dose on 08/05/2010.

He was admitted for allogenic stem cell transplant.

SIGNIFICANT FINDINGS:

- Physical Examination: non contributory
- Laboratory Data: 11/08/10 WNL except RBC – 2.55, HGB – 7.9, HCT – 23.5, RDW – 20.6, LYMPH – 5.7, EOS – 17.9, ABS LYMPH – 0.3, ABS EOS – 0.9, PT – 14.0, INR – 1.26, CALCIUM – 8.4, GLUCOSE – 117, TOTAL PROTEIN – 6.1, ALBUMIN – 3.8, PHOSPHORUS – 4.3, LDH - 304

DIAGNOSTIC/THERAPEUTIC PROCEDURES:

- Culture:
  1) 11/22/10 infusaport blood showed Coagulase negative staphylococcus
  2) 11/22/10 CVC blood white port positive for Coagulase negative staphylococcus

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3) 11/28/10 peripheral blood positive for Enterobacter cloacae

- Procedure:
  1) 11/08/2010: IR performed Hickman catheter placement
  2) 11/24/2010: IR performed removal of triple lumen Hickman catheter

COURSE AND OTHER TREATMENT: On admission, patient was started on IV hydration. He was given antiemetics, oral care, strict I's and O's were monitored and bowel regimen was initiated. Triple-lumen Hickman catheter was inserted on 11/08/10. Standard pre-transplant preparation was started with antimicrobials, antiemetics, proton pump inhibitors, bowel regimen, and IV hydration. Standard VOD prophylaxis was continued with heparin.

He received hyper fractioned TBI for total of 1375 cGy from 11/09/2010-11/12/2010. Cytoreduction was begun with Thiotepa, given from 11/13/2010-11/14/2010, and Cyclophosphamide from 11/16/2010-11/17/2010. Chemo supportive medications were given as needed.

He had large volume diarrhea which was c. difficile positive on 11/17/10.

Unmodified Peripheral blood allogenic stem cells were transfused on 11/19/10 with 8 x 10^6 CD34+ cells/kg. GCSF was started on 11/25/10.

His labs showed raised creatinine. Renal service followed patient for renal failure.
On 11/22/2010, patient developed tachycardia with rapid atrial fibrillation, Metoprolol was given. CCM service evaluated the patient and Cardizem was given as ordered. He was started on IV hydration, 2 units of PRBC'S were transfused and antibiotics were adjusted as necessary. He was transferred to ICU for possible sepsis and worsening renal and hepatic function.

Blood cultures from the CVC showed presence of gram positive cocci. TPN was held. Right upper quadrant sonography on 11/23/2010 was negative for VOD.
On 11/24/2010 he developed rapid atrial fibrillation and required multiple vasopressor for hypertension. Left subclavian CVC was placed emergently and tunneled CVC was pulled by IR. Antimicrobials coverage was broadened for possible sepsis coverage. He continued to require vasopressors and heart rate remains difficult to control despite of Amiodarone and Digoxin. ECHO on 11/28/2010 showed normal LV function with EF 68%. The respiratory status of the patient along with mental status declined and third pressor was started due to progressive hypotension. He was intubated on 11/27/10. He was ventilated on PC mode with FiO2 100% and PEEP 8 and CXR revealed increased bibasilar opacities and effusions. He had anasarca.

The patient's condition and prognosis were discussed with the family and it was elected that the patient be placed on DNR status on 11/28/2010 due to indefinite multiorgan failure. In spite of full supportive measures, the patient's condition continued to deteriorate. The patient expired at 9:58 PM on 11/28/2010. Consent for autopsy was not obtained.

CONSULTATIONS:
CCM service
Infectious disease service

(7)

Patient Name: JOHNSON,STEPHEN Medical Record No: 35197181
Date: 11/08/2010 - 11/28/2010 Page: 3

Cardiology service
Renal service

DISCHARGE STATUS
Patient Condition: Expired

DISCHARGE DIAGNOSIS:
Chronic lymphocytic leukemia with Richter transformation s/p unmodified peripheral blood stem cell transplant from matched unrelated donor
C. difficile colitis
Coagulase negative staphylococcus and Enterobacter bacteremia
Acute Renal failure likely secondary to Tacrolimus
Respiratory insufficiency
Rapid Atrial fibrillation
Urosepsis
Cardiopulmonary arrest
PREPARED BY: RATI GOYAL on 12/14/2010 08:41 AM

Report Electronically Signed Out by HUGO R CASTRO-MALASPINA, MD on 12/14/2010 09:36 AM

External CC:

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Family Member Affidavits

Gresy Johnson

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---------- X

In Re:

TERRORIST ATTACKS ON SEPTEMBER 11, 2001

03-MDL-1570 (GBD)(SN)

---------- X

RAYMOND ALEXANDER, et al.,

Plaintiffs,

V.

ISLAMIC REPUBLIC OF IRAN,

Defendant.

---------- X

AFFIDAVIT OF GRESY JOHNSON

21-CV-03505 (GBD)(SN)

STATE OF NEW JERSEY)
: SS
COUNTY OF SOMERSET)

GRESY JOHNSON, being duly sworn, deposes and says:

1. I am a plaintiff in the within action, am over 18 years of age, and reside at [redacted]

2. I am currently 54 years old, having been born on [redacted]

3. I am the wife of Decedent, Stephen Johnson, upon whose death my claims are based. I submit this Affidavit in support of the present motion for a default money judgment for the claim made on behalf of my husband's estate and for my solatium claim. On June 7, 2004, I was issued Letters Testamentary as Administrator of my husband's estate by the Middlesex County Surrogate's Court.

4. My husband passed away from Chronic Lymphoid Leukemia/small Lymphocytic Lymphoma on November 28, 2010 at the age of 47. It was medically determined that this illness was causally connected to his exposure to the toxins resulting from the September 11, 2001, terrorist attacks at the World Trade Center.

5. Stephen and I met while we worked at Cygne Design, a manufacturing company. As Stephen was the youngest of children in his family, he was very family oriented, loving and kind. From the moment we started dating in 1992, we never spent a moment apart. We moved in together and lived in Miami for two years and continued to work there until moving back to New Jersey where we called to be closer to family and friends. On the day Stephen proposed, he had already spoken to his parents and my mom asking for my hand. Chivalry at its best. I remember he proposed in a pumpkin patch, and it was one of many happy moments together. Shortly after getting married, we became parents to two boys, Nicolas, and Samuel. Much like my darling, Stephen, our boys loved the game of baseball and as they grew older, Stephen taught them how to play. My fondest memory of Stephen was when he brought home baseballs and asked me to color the stitches on the ball. I was completely clueless as to why he would have me do this until I saw him telling the boys to call out the color of the balls, he pitched to them while catching it teaching them hand eye coordination. Stephen was very involved with the boys and taught them lessons of fairness and honesty while coaching them when they started to play sports.

6. On September 12, 2001, my husband went to work at his business, Blue Bench located on Duane Street between Broadway and Hudson Street , a children's furniture store. When he arrived, he discovered that the Red Cross had stationed their temporary headquarters in front of his business- three near blocks away from the site where the World Trade Center once stood. Red Cross workers would traffic into his store for restrooms or to use the kitchen, and Stephen would assist them with what they needed while attempting to salvage his business. After a few weeks, it

appeared as though things were starting to return to normalcy and Stephen reported to work every day.

7. After 9/11, Stephen started to develop migraines and a terrible cough that persisted for months. In April of 2009, after having multiple test done, Dr. Popeck was able to confirm that Stephen had cancer. From that point, Stephen spent most of his days toggled between going to radiation treatments and doctor appointments for blood work and other testing. Unlike his normal personality, he became depressed and had mood swings from the agonizing body aches and pain from the vigorous treatments. Friends would come by to watch my boys while I would take Stephen back and forth to the hospital and bring us dinners to lessen some of the load on me.

8. After a year of radiation to no avail, Stephen began chemotherapy as well. The chemo withered away at his body causing him to lose a lot of weight and then losing his hair. Despite his condition, Stephen still went to the boys game and stood at a distance to prevent encountering anyone who could make him sick being that his immune system was severely compromised. In November of 2010, the doctor ordered Stephen a bone marrow transplant that his body rejected leading him to need ICU care. Within 2 weeks of entering the ICU, my darling husband and sons' father, passed away after we prayed and whispered in his ear reassuring him it was okay to let go. Our lives were shattered forever, and we have never been the same since.

9. Since my darling, Stephen, has passed away my boys and I have not been the same. We have no choice but to be thankful for the countless memories we were able to share with him, but we know nothing will bring him back. However, we remember his kindness, his loyalty, his love of life and everyone around us. His way of teaching my boys to be true to themselves, to own up to their mistakes, to be an honorable man, kind and treat everyone as equals and forgive and not judge because you never will know when you will be in that person's shoes. Stephen's death was

not only devastating emotionally and physically, but also financially. We eventually had to sell the only home we had made on our own in Metuchen and move to Somerset. We miss him every single day and second of our lives, but of course on days like his birthday and ours, special occasions- Father's Day, Thanksgiving, Christmas. He was the love of our lives and now he is our angel in heaven watching over us forever until we meet again.

Grosy Johnson

Sworn before me this

15 day of Aug, 2023

Notary public

ROMIN SHAH
Commission # 2384239
Notary Public, State of New Jersey
My Commission Expires
04/03/2024

Nicolas Johnson

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
---------- X

In Re:

TERRORIST ATTACKS ON SEPTEMBER 11, 2001

03-MDL-1570 (GBD)(SN)

---------- X
RAYMOND ALEXANDER, et al.,

AFFIDAVIT OF NICOLAS JOHNSON

Plaintiffs,

21-CV-03505 (GBD)(SN)

V.

ISLAMIC REPUBLIC OF IRAN,

Defendant.
---------- X

STATE OF PENNSYLVANIA)
: SS
COUNTY OF PHILADELPHIA)

NICOLAS JOHNSON, being duly sworn, deposes and says:

1. I am a plaintiff in the within action, am over 18 years of age, and reside at [redacted]

2. I am currently 26 years old, having been born on [redacted]

3. I am the son of Decedent, Stephen Johnson, upon whose death my claim is based, and submit this Affidavit in connection with the present motion for a default judgment and in support of my solatium claim.

4. My father passed away from Chronic Lymphoid Leukemia/small Lymphocytic Lymphoma on November 28, 2010, at the age of 47. It was medically determined that this illness was causally connected to his exposure to the toxins resulting from the September 11, 2001, terrorist attacks at the World Trade Center.

5. Steve Johnson was my father and ran his own children's furniture company in Manhattan. My relationship with my dad was as any 13-year-old would be idolizing him and wanting to be exactly like him. I always gravitated towards him because of our shared interest in playing and watching sports together and playing video games. My dad was an athlete and absolutely loved the Yankees. He loved to play sports with me and my younger brother, Sam, varying from wiffle ball in the backyard or suiting up as a hockey goalie for the neighborhood kids. At one point, my dad even began coaching little league games throughout our childhood years. He always wanted us to excel, but more importantly he cared about everyone participating and getting a fair chance.

6. One of my fondest moments with my dad was the year that he coached me and my brother's little league team, and I broke the town homerun record under his guidance. He was so proud of me and gave me a hug as I rounded third base before heading home. We won the championship that season and he was so happy to experience that for the first time with his two sons on the same team. Our shared love for sports made our relationship grow at an early age and is something I will always appreciate. I remember attending my first games with him, staying up late to watch playoff games, and even the first Superbowl when the Giants beat the Patriots. I remember he bought me a Superbowl edition Plaxico Burress jersey that I wore to school the following day. Fifteen years later, I keep the jersey in my room not only to commemorate the day that the Giants won, but as memorabilia of my relationship with the coolest dad someone could ask for.

7. My dad was also a gamer and I recall when he purchased the GameCube for us, we were the first family with a gaming system and that purchase contributed to so many memories with my friends and brother growing up. We would sit for hours, playing

Super Mario Party 5 and although I tried so hard to beat him, I simply couldn't. Simply put, video games later became a pass time and stress reliever even to this day. I'm thankful that my dad introduced me to them.

8. On 9/11, I was only 4 years old, but still remember being pulled out of school and watching the attacks on tv in the living room. I remember my dad being at work in Tribeca at his furniture store within the exposure zone.

9. Since my brother and I were eight and ten years old at the time of my dad's diagnosis, we were shielded from his disease for the most part until it became serious. Even as I started to get a better understanding of the picture, I never thought he would die, and no matter how much weight or hair he lost, I never looked at him as sick. I just saw him as my dad and wanted to live our normal life. We would occasionally visit Memorial Sloan Kettering, but my brother was too young to visit his floor and wouldn't allow him to see his own father. We stuck to Skype after these incidents of visitation denials. I think my dad tried his hardest to hide the effects of his illness and treatments from us, giving all his energy to still try and play catch with us in the yard or attend one of our games. The last time he left the house, he told me to "Just Be a Kid" and that's a motto that I held close to me and even printed on custom sneakers or wrote on the brim of my baseball cap growing up. I never thought he wouldn't return home and it still gives me the chills thinking about the last time I gave him a hug goodbye in our old home.

10. I lost my dad at 13 years old and still remember that last day in the hospital. I went to church with my friend Evan, and as soon as mass concluded I got a call from a family friend who lived around the block and said we had to leave for Sloan Kettering immediately. I still did not realize the severity of the situation and believed like any 13-year-old that their dad would recover from this illness and return home. We drove into the city and rushed up to his floor where

we saw him for the first time, and it hit me that things were not okay. I remember screaming when he was pronounced dead late that evening. From then on, I had to be the man of the house, taking care of my mom and brother. At the funeral my mom was unable to read the eulogy, so I had to step to the podium in front of hundreds of people there to support my family and deliver a speech in my dad's honor. A family friend who I still talk to today told me, "That was bigger than any homerun you've ever hit." His influence in our small town of Metuchen, NJ did not go unnoticed when he passed, as one of the baseball fields was named in his honor shortly after his death.

11. It was hard growing up in a single parent household, as hard as my mom tried and I missed out on the best years of a father-son relationship since his passing. I was too young to talk about girls, share a beer, exchange college stories, talk about work etc. After his passing, I always said I felt robbed that I never got to experience any of these things with him and the craziest part is that this year will mark the same amount of time I've lived with and without him. Every major accomplishment of my life has been missing from the bleachers or the building and that is always a sad feeling during a moment of happiness. What I took away from him was how to be a good person and how to make others feel wanted and included. I take pride in trying to lead by example and make him proud. A lot of people say I'm just like him, and that is the biggest compliment in the world.

NICOLAS JOHNSON

Sworn before me this
18th day of September 2023
Jimmy Mota
Notary public

Commonwealth of Pennsylvania - Notary Seal
JIMMY J MOTA - Notary Public
Philadelphia County
My Commission Expires March 21, 2027
Commission Number 1432858